Connecticut Department of Social Services

Making a Difference

Testimony before the Appropriations Committee

Governor's Recommended SFY 2012 & 2013 Biennial Budget

Commissioner Michael P. Starkowski

March 4, 2011

Good afternoon, Senator Harp, Representative Walker and members of the Appropriations Committee. My name is Michael P. Starkowski, and I am the Commissioner of the Department of Social Services. I am pleased to be here before you today to testify in support of the Governor's Recommended Budget for DSS. I am accompanied today by Deputy Commissioner Claudette Beaulieu and senior DSS managers.

In these difficult times, it is critical that we strive to meet the needs of Connecticut's residents while always being cognizant of the continuing budget and economic pressures the state is under. I am thankful for Governor Malloy's reasoned and caring approach to maintaining a strong package of services for Connecticut's neediest residents -- at a time when other states are cutting deeply into critical human service programs.

While the urgent need to control spending means that there will be some service reductions and cost-sharing increases in the DSS budget, *the safety net remains intact and caseload growth for the major entitlement programs is funded.*

As I have testified on previous occasions, with DSS representing 31% of the overall state budget, we recognize that we have to be a significant part of efforts to balance the state budget. The Governor's budget recommendation includes $5.62 billion for DSS in SFY 2012 and $5.75 billion in SFY 2013. The Governor's recommended adjustments to current services projections are a net reduction of $56.7 million in SFY 2012 and $57.7 million in SFY 2013, for a total net reduction over the biennium of $114.4 million, or approximately 1% in the first year and 1% in the second.

The Governor's budget text noted some examples in the health and human services arena that best demonstrate the difficulty of the choices we face this year. Limits on non-emergency adult dental and vision services (optional benefits under the Medicaid program) will be necessary to preserve core coverage. The imposition of Medicaid co-pay requirements exemplifies the need for shared sacrifice. The Medicaid for Low-Income

Adults program will see greater utilization management, benefit and rate changes, and potential co-pays, because only with these cost controls can we keep up with the expenditure demands of program growth.

Again, consistent with the Governor's commitment to maintain the safety net for the state's most vulnerable citizens, this budget maintains critical programs and provides funding for significant caseload growth .

The Governor's budget includes significant funding in recognition of the increased caseload and utilization growth in many programs. Areas of substantial growth include HUSKY A and Medicaid fee-for-service. HUSKY A caseloads are expected to increase by 37,500, from 398,800 to 436,300 by the end of the biennium, requiring additional funding of $70.7 million. Caseloads under Medicaid fee-for-service, excluding Medicaid for Low Income Adults, will grow approximately 8% over the biennium. A total of $104.7 million has been added to the DSS budget to support this increased caseload and utilization. Another $62.1 million has been included for Medicaid for Low-Income Adults to support medical costs associated with a 25% caseload increase for this population over the biennium.

In his budget address, Governor Malloy stated his desire to move Connecticut forward on the issue of public health. The addition of smoking cessation services for all Medicaid clients, effective January 1, 2012, exemplifies this commitment.

Last year's budget incorporated the federal economic stimulus package and allowed us to hold many of our services in place due to increases in Medicaid reimbursement beyond Connecticut's normal 50% Medicaid partial match rate. CT like other states will have to weather the impact of losing these federal stimulus dollars. But make no mistake we are committed to pursuing every opportunity for enhanced funding made available through health care reform or other federal venues.

- Governor Malloy's budget recognizes a major expansion of our Money Follows the Person program. This expansion takes advantage of approximately $21 million additional federal dollars for rebalancing our long-term care services through 2016.
- The majority of direct service programs rely on financial eligibility and we continue to rely on a system that was designed in the late 80's and installed in the early 90's. Recently the Center for Medicare Medicaid Services advised states of new federal financial support for states to develop and upgrade Medicaid information technology systems. Governor Malloy's budget provides the seed money and staffing to begin the planning and development of a replacement state-of-the-art eligibility system.
- In the federal Reauthorization of the Children's Health Insurance Program financial incentives were made available to states that met criteria designed to enhance outreach and expedite enrollment of eligible children. Governor Malloy's budget reflects the implementation of presumptive eligibility for HUSKY B children allowing CT to receive federal incentive dollars.

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While Governor Malloy's budget recommendation for the 2012-2013 biennium preserves the safety net and supports projected caseload growth in our entitlement programs, the Governor has already taken the initiative to begin moving our health programs forward in three significant areas. On February 8, Lieutenant Governor Wyman and OPM Secretary Barnes announced the Malloy/Wyman Administration's directive to:

- Restructure DSS health coverage programs into a self-insured 'administrative services only' format;
- Expand the Money Follows the Person program to help deinstitutionalize elders and adults with disabilities; and
- Extend 'presumptive eligibility' coverage of children in HUSKY B (Children's Health Insurance Program).

'ASO' Structure for HUSKY, Medicaid and Charter Oak

The Governor's budget recognizes that the department will be issuing a request for proposals to move to a self-insured 'administrative services organization' (ASO) model. Effective January 1, 2012, the new model will replace managed care for HUSKY A & B and the Charter Oak Health Plan; and the current unmanaged Medicaid fee-for-services (FFS) model for the Aged, Blind and Disabled (ABD) and Low-Income Adults (LIA) populations. The new ASO structure will be responsible for managing care for nearly 600,000 medical care beneficiaries, and will allow for greater administrative efficiencies for both the state and the provider community. The state will assume the financial risk and responsibility to pay medical costs for our beneficiaries. The change will also result in greater transparency and accountability than under the former model. The ASO structure will provide assistance with referrals and appointment scheduling and will help recipients to better navigate the health care system. The ASO structure will also provide a range of management services including centralized customer call center services, utilization management, care coordination, care management, predictive modeling, health risk assessment, provider performance measurements and other administrative services. It is also anticipated that over the next several years, the ASO structure will provide technical assistance in the field to support the emergence of medical homes, health homes, and other service delivery innovations, such as Integrated Care Organizations. Experience in other states has demonstrated savings while improving health outcomes with medical homes, a person-centered approach to providing comprehensive primary care. There is a federal emphasis on these types of programs, and this change positions us to be better aligned with federal health care reform and funding opportunities. The department is on track to issue an RFP for ASO services this month with the goal of having the ASO model operational by January 2012.

Money Follows the Person (MFP)

As mentioned earlier, the Governor has approved a major expansion of the "Money Follows the Person" (MFP) program for seniors and adults with disabilities leaving long-term facility-based care for community living. Enhanced federal funding is available under this rebalancing demonstration grant to incentivize states to transition individuals out of institutional settings to the community. MFP coordinates the services necessary, such as home health, home care, housing assistance, and other supports, to provide a safe and secure transition.

Based on the principles of consumer choice and "person-centered" consumer direction, MFP was initially funded in 2007 to achieve six goals:

- Transition 700 people from institutions to the community;
- Increase the supply of home and community-based services;
- Increase hospital discharges to the community rather than to institutions;
- Increase an individual's probability of returning to the community within the first six months of admission to an institution;
- Increase the percentage of long-term care participants served in the community compared to institutions; and
- Ensure that procedures are in place to provide quality assurance and continuous quality improvement of home and community-based services.

The state receives enhanced federal Medicaid reimbursement for the first year of an individual's transition from an institutional setting back into the community, and is required to reinvest the differential of enhanced dollars received in MFP activities aligned with one of the established six goals. In Connecticut, this reinvestment occurs through the Medicaid program with assurances that the individual's community care needs are fully met. MFP operates in partnership with other state agencies and a diverse steering committee to assure consumers, providers, and advocacy groups have a voice in the design and implementation of activities.

To date, MFP has transitioned 503 individuals back into the community. In January 2010, the department increased the projected number of transitions from 700 to 890. Demand for transitional supports continued to grow throughout 2010, with over 200 individuals at various stages of the transition process. By the end of 2010, MFP was achieving benchmarks in all six goal areas. To address the increased demand, the federal government authorized additional funding for staff. The first comprehensive reports on quality of life were published indicating that persons who transitioned were enjoying a much higher quality of life in the community compared to the institution

Community placements on average are less costly than institutional placements. As the number of individuals transitioning from institutions increase, the Governor has directed DSS to request additional funding from the Centers for Medicare and Medicaid Services (CMS) to increase the number of transitions to 5,200 through 2016. CMS has also approved DSS' request to design, develop and implement a strategic rebalancing plan

that will provide guidance for institutional business diversification opportunities and training that qualifies for 100% federal funding. This will bring an estimated $21 million in revenue to Connecticut over 6 years. DSS recognizes that institutional providers may choose to diversify their long-term care business model to include the provision of home and community based services.

The MFP expansion results in significant savings to the state. This savings occurs as a result of multiple impacts the additional MFP transitions are anticipated to have on our long-term care system. These multiple impacts include: (1) a direct reduction in nursing home occupancy, as Medicaid-eligible clients are served in more appropriate community-based settings; (2) the expected impact of the institutional business diversification opportunities and training initiatives to support nursing homes as they transition into alternative service provision; and (3) the unavoidable closure of financially distressed facilities as declining nursing home utilization trends are magnified by additional MFP transitions. These result in estimated nursing home savings of $32.2 million and $69.9 million in SFY 2012 and SFY 2013, respectively.

Presumptive Eligibility for HUSKY B

The Governor has authorized DSS to extend presumptive eligibility to HUSKY B children with family incomes between 185% and 300% of the federal poverty level. This change will allow the state to qualify for an enrollment/retention bonus under the Children's Health Insurance Program Reauthorization Act (CHIPRA) late in calendar year 2011. With minimal additional expenditures required to implement presumptive eligibility, the bonus is expected to be in the range of $1 - $4 million, and children under HUSKY B will receive coverage sooner, consistent with the process in place for children currently served under HUSKY A.

We are on track to implement effective April 1 for federal bonus dollars during state fiscal year 2012.

RBA Impact: Approximately 400 individuals will be enrolled under Presumptive Eligibility; 90% would have been granted even without PE but will be enrolled earlier (1 to 2 months on average)

Significant DSS savings initiatives in the Governor's Budget include the following:

Health Care Services:

- **$83,275,000 savings in SFY 2012 and 2013 by eliminating funding for Disproportionate Share Hospital (DSH) Grants**

Both the Disproportionate Share - Medical Emergency Assistance account and the DSH - Urban Hospitals in Distressed Municipalities account provide disproportionate share payments to acute-care general hospitals that serve a large number of low-income patients, such as people on Medicaid and the uninsured. These payments are in addition to the regular payments hospitals receive for providing inpatient care to Medicaid beneficiaries. As a result of the recent Medicaid expansion to low-income adults (LIA), hospitals are receiving significantly more than the funding that they received from the capped appropriation under SAGA. This change eliminates funding for the two DSH accounts. Furthermore, under federal health care reform, DSH payments to states will be significantly phased down beginning in 2014.

- **$29.3 million in SFY 2012 and $32 million in 2013 to Reverse Recent Change to Marital Asset Exemption for Community Spouses**

Legislation from last session requires that the spouse of someone in an institution who remains in the community be allowed to receive the maximum amount of assets permitted under federal law. With this change, Connecticut became one of only 14 states to allow the community spouse to keep up to the federal maximum of $109,560. Prior to the passage of PA 10-73, non-institutionalized spouses were allowed to keep the home, one car and one-half of the couple's assets (with a minimum amount of $21,912) without affecting the institutionalized spouse's eligibility for long-term care Medicaid assistance. These asset levels are much higher than the vast majority of states, which use the federal minimum of $21,912, with a few states using a slightly higher minimum. With this change, the state's prior asset exemption of 50% of liquid marital assets, capped at $109,560, would be reinstated.

<u>RBA Impact</u>: 1,800 spouses per year approximately

- **$9.8 million and $10.3 million in SFY 2012 and 2013, respectively, to Reduce Non-Emergency Dental Services for Adults under Medicaid**

Less than half of the states provide full dental benefits for adults under their Medicaid programs; most states have annual expenditure caps or provide only emergency coverage. In the last few years, many states have reduced or eliminated adult non-emergency dental benefits offered through Medicaid. The Governor's budget calls for changes to be made to the current dental benefits for adults that will reduce the overall program expenditures while maintaining services that will prevent further disease, unnecessary emergency department use and maintain appropriate oral health. Changes include limiting adult periodic exams, cleanings and bitewing x-rays to once per year for healthy adults.

- **$6.3 million in SFY 2012 and $7 million in SFY 2013 savings by restructuring Non-Emergency Medical Transportation under Medicaid**

DSS currently pays for ambulance service for individuals who are stretcher bound but do not require medical attention during transport. We are expanding transportation options

under Medicaid to include stretcher van service for those individuals who are medically stable but must lie flat during transport. The new stretcher van rate will be significantly less than the non-emergency ambulance rate, which has a base rate of $218 plus $2.88 per mile (approximately $275 for a 20 mile one-way trip). This change is consistent with at least twelve other states that have recognized the economic value of stretcher vans in their Medicaid programs. Under this restructuring, clients will continue to be safely transported.

- **$3 million in SFY 2012 and $6.5 million in SFY 2013 savings by Implementing an Alternative Benefit Package and Other Programmatic Changes under the Medicaid Low Income Adult Program**

To address the significant growth in the new coverage group for low-income adults (LIA) under Medicaid - well beyond budgeted levels - this option reflects savings associated with the implementation of an alternative benefit package, rate changes, targeted co-pays and eligibility changes that will return the program to its original target population: those who were eligible for SAGA medical.

RBA Impact: 72,900 LIA average projected enrollment in SFY 2013.

- **$5.5 million savings in SFY 2012 and $5.75 million in SFY 2013 by Increasing Cost Sharing under the State-Funded Connecticut Home Care Program**

A client cost sharing requirement of 15% under the state-funded Connecticut Home Care program was introduced through PA 09-5, September special session. This requirement was reduced to 6% under PA 10-179. The cost sharing requirement will be returned to 15% under this recommended change.

- **$1.8 million in SFY 2012 and $2.1 million in SFY 2013 in savings by Freezing Intake on Category 1 level of care**

The state-funded portion of the Connecticut Home Care Program provides home and community-based services to elderly who are at risk of nursing home placement and meet financial eligibility criteria. Category 1 is targeted to individuals who are at risk of hospitalization or short-term nursing facility placement if preventive home care services are not provided. Category 2 is targeted to individuals who are frail enough to require nursing facility care, but have resources that would prevent them from qualifying for Medicaid upon admission to a nursing facility. This proposal closes intake for Category 1 under the state-funded program. While this proposal does not impact existing clients, DSS has identified a new opportunity under the 1915(i) state plan option that will allow the department to transfer the cost of Category 1 services provided to dually eligible clients under the state-funded program to Medicaid and claim reimbursement. To the extent that this is cost effective and based on federal approval, DSS will implement a program under Medicaid for Category 1 clients who are dually eligible. Intake to the

state-funded program for Category 1 will be closed, but intake under the newly established 1915(i) Medicaid program will continue for those who qualify.

- **$7.24 million in SFY 2012 and $12.4 million in SFY 2013 to Limit State-Funded Premium Assistance under the Charter Oak Health Plan**

Last year, as part of deficit mitigation efforts, premium assistance under the Charter Oak Health Plan was limited to clients who were enrolled in the program as of June 1, 2010. Under this measure, premium assistance was scheduled to resume for all clients beginning July 1, 2011. Under the budget recommendation, premium assistance will continue to be limited to clients who were enrolled in the program as of June 1, 2010. Individuals who choose to enroll in the Charter Oak Health Plan will be responsible for the full premium costs.

- **$4.79 million savings in SFY 2012 and $4.94 million in SFY 2013 by Reducing State-Funded Premium Assistance under the Charter Oak Health Plan**

Currently, individuals with income at or below 300% of the federal poverty level, enrolled in the Charter Oak Health Plan as of June 1, 2010, receive state-funded premium assistance ranging from $50 to $175 depending on income. Under this proposal, state-funded premium assistance will be reduced by approximately 35% and will range from $35 to $115, depending on income. Clients will be responsible for a greater share of their health care costs.

RBA Impact: SFY 2012 14,297 enrollees, increasing to 17,247 in SFY 2013.

- **$76.3 million in SFY 2012 and $82.7 million in 2013 to implement the recommendations of the Pharmaceutical Bulk Purchasing Committee for DSS**

The Governor's recommended budget reflects lowering DSS' reimbursement to the level of those under the state employee health program. This initiative would reduce the reimbursement by a change in the discount off of the average wholesale price (AWP) and a reduction in the dispensing fee.

RBA Impact: 646,000 individuals based on projected average enrollments over the biennium (525,000 Medicaid, excluding LIA; 69,700 LIA; 15,800 Charter Oak; 15,300 HUSKY B; 18,500 ConnPACE; 2,000 CADAP)

- **$1.84 million savings in SFY 2012 and $4.18 million in SFY 2013 by Implementing Medication Administration for Certified Providers**

Currently, only nurses may administer medication in home and community based settings. Home health aides may be part of the care team in an individual's home, but they are not permitted to administer medication. Under this option, specially trained and

qualified home health aides will be allowed to administer oral and topical medications and eye drops. Nurses will still be required to administer all injections as well as those medications that are specified by a physician to be administered only by licensed personnel.

- **$4.38 million in savings in SFY 2012 and $4.13 million in SFY 2013 to Continue ConnPACE benefits only for individuals who are not eligible for Medicare Part D**

For the majority of ConnPACE enrollees, ConnPACE is the secondary payor to Medicare Part D. ConnPACE recipients are required to exhaust their Part D benefits under Medicare. The department pays any co-pays above $16.25 and any premiums and deductibles, as well as any coverage gap costs, for those enrolled in Medicare Part D. With the recent increase in income eligibility under the Medicare Savings Programs (MSP), ConnPACE clients who are Medicare eligible are encouraged to enroll in MSP, which makes them eligible for the federal low income subsidy under Medicare Part D. As a result, prescription co-pays are reduced from a maximum of $16.25 to no more than $6.30 (co-pays could be as low as $1.10). In order to contain costs, ConnPACE coverage for individuals who are eligible for Medicare can be eliminated. Those clients who are Medicare eligible, but who do not otherwise qualify for the federal low income subsidy, will need to enroll in MSP to ensure their pharmacy costs remain affordable. By doing so, they will also be able to take advantage of the assistance provided under MSP. The remaining estimated 110 clients not eligible for Medicare Part D benefits will be grandfathered under the ConnPACE program and will continue to receive assistance.

- **$2.2 million and $2.3 million savings in SFY 2012 and 2013 to Revise Medicare Part D Co-payment Requirements for Dually Eligible Clients**

Currently, persons dually eligible for Medicare and Medicaid are responsible for paying up to $15 per month in Medicare co-pays for Part D-covered drugs. Connecticut is one of only a few states assisting dually eligible clients with the costs of the Medicare Part D co-payments, which range from $1.10 to $6.30 in 2011. Under this proposal, dually eligible clients will be responsible for paying up to $25 per month in Medicare co-pays for Part D-covered drugs.

RBA Impact: There were 67,500 dual eligibles as of January 2011.

- **$68.9 million savings in SFY 2012 and $95.5 million in 2013 to remove rate increases for nursing homes and to modify the nursing home user fee.**

Existing statute includes various mechanisms for rate increases for nursing homes; in order for the state to control expenditures; this legislation eliminates those specific rate increases over the biennium.

However, **a rate increase is being put forward for nursing homes under a proposal that would restructure nursing home user fees.** This proposal would institute a user fee. The fee, set at 5.5% until 10/1/11 when it would increase to 6%, is expected to raise $34.3 million in revenue in SFY 2012. Nursing home rates will be increased by an equivalent amount, with an additional $17 million in federal funds earned as a result also incorporated into the rates. This will result in an annualized rate increase of $51.5 million, or a net increase to nursing homes of $28.8 million over the biennium.

- **$1.1 million and $2.4 million savings in SFY 2012 and 2013 to Restructure Medicaid Reimbursement for Certain Hospital Outpatient Services**

DSS currently sets rates for outpatient hospital services that are paid using revenue center codes. Some codes are fixed fees - a specific dollar amount for a code and every hospital approved for that code gets the same amount. Other outpatient services are paid a percentage of cost to charges - the ratio is hospital specific and code specific based on the hospital department where the costs and charges are reported. DSS will implement state-wide fixed Medicaid fees for certain outpatient services that are now paid based on hospital specific ratio of cost to charges. In addition, the department will pay for outpatient pharmacy services based on the pricing system used for community pharmacies.

- **$11.25 million over the biennium for Tobacco Cessation under Medicaid**

Effective October 2010, Connecticut began providing smoking cessation coverage for pregnant women on Medicaid as required under federal health care reform, but smoking cessation services for other Medicaid recipients are not yet covered. Medicaid recipients are at higher risk for tobacco addiction than the general population because low income is a variable strongly associated with tobacco use. In 2006, Massachusetts began providing a smoking cessation benefit for Medicaid beneficiaries and in the first two and a half years, the smoking rate fell 26% with corresponding decreases in heart attacks and emergency department visits for asthma symptoms among cessation benefit users. As mentioned at the beginning of my testimony, under this proposal, tobacco cessation services will be extended to all Medicaid recipients beginning January 1, 2012. This benefit is expected to improve health outcomes and result in significant savings over the long term.

Non-Health Care Services:

- **Provide funding to Upgrade DSS' Eligibility Management System: $1.6 million in SFY 2012 and $453,000 in SFY 2013**

The replacement of DSS' Eligibility Management System (EMS) is long overdue, but has been delayed due to costs projected at $100 million or more. With the passage of the

Affordable Care Act and the need to have state systems in place on January 1, 2014, to support the operation of exchanges, states that streamline and upgrade their Medicaid eligibility systems to provide a simple and seamless enrollment experience for consumers who qualify for Medicaid or who are shopping for health insurance in the exchanges will be eligible for 90% federal reimbursement. This enhanced reimbursement applies to the design, development and installation of automated Medicaid eligibility systems and is unprecedented. Recognizing this opportunity, funds are provided for consultation services and staff to assist with the procurement and development of a new eligibility system.

- **$6.3 million in SFY 2012 and $12.5 million in 2013 to Suspend Cost of Living Adjustments for Clients on Public Assistance**

Effective July 1, 2011 and July 1, 2012, recipients of Temporary Family Assistance, State Administered General Assistance, and the Aid to the Aged, Blind and Disabled programs are scheduled to receive a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index - Urban (CPI-U). This recommendation eliminates the standards increases for the biennium.

RBA Impact:

	2012	2013
OAA	4,698	4,733
AB	84	87
AD	10,923	10,865
TFA	21,011	21,063
SAGA	5,516	5,624
Total	42,232	42,372

- **Provide RAP Certificates for New Supportive Housing Units: $775,850**

The proposed capital budget for the upcoming biennium includes $30.0 million in SFY 2012 for supportive housing initiatives under the Department of Economic and Community Development. This option provides half-year funding in SFY 2013, which is when we anticipate those units will become available, to cover Rental Assistance Program (RAP) certificates for 150 units.

Additional Written Comments:

- **$450,000 to $500,000 savings by Implementing Changes to the Security Deposit Guarantee Program**

Several changes to the Security Deposit Guarantee Program will be implemented to strengthen program criteria and enhance identification of fraudulent claims. The following items are included to generate these savings: 1) the time required before a client can reapply for a Security Deposit will be extended from 18 months to 5 years; 2) the proof of homelessness criteria will be improved to require legal documentation that is filed in court; 3) landlords will be required to provide DSS with receipts (rather than estimates) for the damage caused by the tenant and 4) a small client co-pay will be added to ensure clients have a buy-in in the program. The co-pay will not exceed 10% of one month's rent and may be waived at the Commissioner's discretion.

- **$3.6 million and $7.6 million in SFY 2012 and 2013, respectively to strengthen fraud recovery efforts**

This proposal will result in savings by strengthening fraud recovery efforts in the Child Care (Care4Kids) program, the Personal Care Assistance waiver under Medicaid and in the Third Party Liability Unit. Six positions will be added to expand department oversight, investigate fraud and increase recoveries.

- **Commission on Deaf and Hearing Impaired/Board of Education and Services for the Blind**

Under the Governor's broader proposal to Restructure State Government, the Commission on the Deaf and Hearing Impaired and certain functions from the Board of Education and Services for the Blind will be consolidated within DSS. Funding for the Commission on the Deaf and Hearing Impaired, including five full-time positions and approximately 40 part-time interpreter positions, and funding for the Board of Education and Services for the Blind, including 58 full-time positions, will be transferred to DSS.

- **Conduct MITA State Self-Assessment: $500,000**

In order to improve the effective administration of the Medicaid program and maximize enhanced federal matching funds to support ongoing system operation, modifications, and enhancements, this proposal provides funds to procure consultant services to (1) conduct a MITA (Medicaid Information Technology Architecture) State Self-Assessment and (2) develop an associated MITA strategic roadmap to outline planned improvements in Medicaid business processes and technology support. This effort will support more effective program administration, including better automation of program functions, and timelier and less costly implementation of program initiatives and is federally reimbursable at a rate of 90%.

- **$3.2 million in SFY 2012 and 2013 Reduction in Nurturing Families Network sites**

This proposal will eliminate funding for the Nurturing Families Network at non-hospital sites in New Haven and Hartford, which are the only cities receiving program funding for non-hospital sites. Services will continue to be provided at all 29 birthing hospitals throughout the state, including hospitals in New Haven and Hartford.

- **$1.05 million in SFY 2012 and 2013 to Eliminate certain earmarks and other state-funded programs**

Under this proposal, funding for a variety of non-entitlement accounts and programs within DSS will be eliminated. The following accounts will be eliminated: Children's Health Council, HUSKY Outreach, Human Resource Development and Human Resource Development-Hispanic Programs. In the following accounts, a portion of programs or services will be eliminated: Services to the Elderly, Services to Persons with Disabilities, Housing/Homeless Services, Day Care Projects and Community Services.

- **$ 1. 7 in SFY 2012 and 2013 to Reduce Funding for Non-entitlement accounts**

This proposal reduces funding for the following non-entitlement accounts by 10%: Safety Net Services, Employment Opportunities, Human Service Infrastructure Community Action Program and Teen Pregnancy Prevention. A portion of funding for programs in the Services for Persons with Disabilities and Community Services accounts will also be reduced. These programs have been identified as not essential to DSS' core mission.

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In closing, I would like to express my gratitude to Governor Malloy for proposing a budget that supports our ability to continue providing critical services to higher numbers of individuals and families as reflected in the increasing caseloads.

At this time, I would appreciate the opportunity to respond to any questions you may have. Thank you.